HARVARD MEDICAL

Alumni Bulletin

Christmas, 1965

LETTERS

Bulletin Accused of Frank Journalistic Sadism

To the Editor:

The picture in the Fall issue which displayed the late Doctor Palmer's M.G.H. coat must have delighted his former associates. However, you indulged in this bit of historical fetishism at the wearer's expense and at the risk of offending present associates of the coat's heir.

By positioning the midline of Doctor Pappenheimer's image over the centerfold you achieved an interesting schizophrenic-like aura. To one who places this distinguished physiologist among the most coherent of personalities currently inhabiting the Shattuck Street Quadrangle, this was frank journalistic sadism.

Striking a balance between veneration of a glorious past and proper consideration of a productive present is one of your proverbial challenges, I am sure. But can one neglect the distortion of such a large, centrally placed illustration for a coat pocket pleasantry?

John E. Remmers '63
Los Angeles, California

Editors' Note:

Our sincere apologies to Dr. Pappenheimer. The unfortunate effect of the picture was an error in judgment.

Legalized Narcotics Oversimplification of Drug Problem

To the Editor:

Dr. George Vaillant's pitch to "bean stuffers" (HMAB, Fall 1965) doubtless will find quite a few protagonists even though the author offers odds that legalized access to addictive narcotics would fail in the United States. It has failed in Denmark (Danes consume more than half again as many drugs per capita as any other people in the world*), and in Israel.

As most readers of the HMAB are aware, there are many and varied plans and proposals for "curing" or "halting" the narcotic addict. I am not qualified to discuss either the merits or demerits of these.

I am reminded, however, of an incident that occurred some years ago in a fairly large midwestern city where, at the time, I worked as a news reporter. One of the many beats on which I found myself from time to time was, for want of a better name, known as the "federal" beat. Among its many segments were the postmaster, U.S. District Court, FBI and representatives of the Treasury Department including a few narcotic agents. The latter, as did the FBI, worked out of a major office in a larger city some miles distant. On occasion their duties involved raids and arrests in our area. A small cell was maintained in the Federal Building to house those apprehended until their removal to regional jurisdiction.

One morning I chanced upon a veteran narcotics agent who was engaged in the paper work necessary to the transfer of a young narcotics victim who had been picked up the night before and had spent the night in the small cell. The "morning after" for the young man was anything but pleasant as he suffered the early reactions triggered by a lack of his usual quota. We walked with the agent from the room. He stopped in the adjoining office and vigorously snubbed his cigaret in a convenient ashtray.

He held the twisted and somewhat flattened butt at his fingertips.

"When I think of that young fellow in there," he said, turning the now extinguished butt first this way, then that, "when I think of him, I can't help but feel that despite all of our efforts at 'cures,' all of our educational programs, our school lectures, in spite of everything we try to do, perhaps the answer is right here."

He shredded the butt with his fingers and the loose tobacco fell into the ashtray.

"That first 'thrill' to most of these young fellows is that drag on their first cigaret. Perhaps if we could stop it here it would never get started."

Of course, this too, as Dr. Vaillant and the authorities on narcotics addiction will agree, is an oversimplification of the problem.

But, as "Jack and the Beans," it provides food for thought.

Herbert A. Shaw
Director of Medical Information
Harvard University

*"The Drug Takers" Time, Inc. 1965 p. 118.

HARVARD MEDICAL ALUMNI BULLETIN

Vol. 40 Christmas, 1965 No. 2

Cover: An OP art illustration, designed by Raymond Crane, for the article, "Introduction to the Clinic" (p. 4-7).

Credits: Cartoons, 20, 21, Raymond Crane; Ether Day, 25, 26, 27, John J. Fields; Dr. Berry, 35, Karsh, Ottawa.

The opinions of contributors to the Bulletin *do not necessarily reflect those of the Editorial Staff.*

EDITORIAL

Regional Planning

THE expansion of medical knowledge and the rising cost of medical care demand effective regional planning to organize, distribute and utilize health services rationally for the better care of the sick and injured as well as the prevention of disease and to contain unnecessary expense by the avoidance of duplication or underutilization of costly machinery and the building of unnecessary facilities. We run into difficulty immediately as we argue the virtues and defects of planned, centrally controlled society versus the spontaneously adjusted, unplanned, laissez-faire condition. Rational behaviour in the activities of intelligent, mature men occurs when the goals of such activity are quantifiable, unambiguous, and internally consistent. The values from which the goals are derived must not be in conflict. The laissez-faire society satisfied these conditions with the overriding goal of all economic activity, i.e. profit. Unfortunately, the ends of medicine are not readily quantified, contain many ambiguities, and are not always internally consistent. Furthermore, what may seem rational planning today can be altered overnight by the inexorable advance of medical science and technology even though social and medical values remain the same.

Recognition of the limitations of central planning does not alter the fact that responsible men should attempt to rationalize their activities. Expanding knowledge, rising expectations and rising costs demand that medicine provide a more effective social technology. As regards the development of facilities in the community, it is quite clear that there is, first, better service to be given, and, second, less capital expense to be incurred if the beds and operating rooms and technical facilities are used maximally (which except for cultural difficulties might demand a seven-day workweek). This statement applies most clearly to obstetrical facilities and to the current shibboleths concerning the cobalt bomb, open-heart surgery and organ transplantation. After that, even the most avid planner recognizes that effective regional planning results in increased capital expenditure to improve existing facilities and build new ones, and furthermore, that there are local community needs and initiatives which central planning cannot understand and may ignore or even stifle. The hazards of "equality" — culturally safe mediocrity achieved through weakening the strong in order to improve the weak, which though unintended is guaranteed by "rules and regulations" — must also be guarded against. Restricted State and Federal budgets and inadequate reimbursement formulas for hospital care have contributed to a degeneration of plant and facilities — and adequate money in the future for the funding of depreciation may be the single most important aspect of effective regional planning over the long run.

A wide body of useful knowledge now exists as regards regional planning; some voluntary regional planning councils which include the local financial establishment have operated with marked success. State Departments of Public Health have also planned well for community facilities. Unfortunately, such community service and planning is foreign to most medical schools, their faculties and students; and Schools of Public Health have long since been cut off from the mainstream of medical education. Resistance to regional planning comes not only from religious and trustee groups, but even more importantly from the medical profession itself. It is to be hoped that the Heart Disease, Cancer and Stroke Law with its directed assistance will succeed in fostering rational regional planning where the Hill-Burton program of equality for all failed at least in part.

The first problem becomes one of selecting a politically viable planning unit. One must be able to encompass the problems of a given region in terms of population, cultural characteristics, and political controls. A strongly motivated lay board of directors with the active participation of the medical profession and a staff adequate to the task are absolutely essential. One must have clear-cut values and goals for such planning in the development of community health facilities, which can be stated as follows:

1. The first principle (and the principal goal) is to improve service in the care of the sick and the prevention of disease. Any saving of money is a secondary gain which may not always be achieved because community needs are uncovered which require more personnel and additional capital expenditures.

2. Local initiative must be encouraged by active participation and understanding of all segments of the community.

3. The rational as well as the irrational needs of patient and physician must be considered by the planning board, for although planning for facilities can be rationalized, the behaviour of doctors and patients is not always predictable or rational. The intensely personal nature of their relationship cannot be ignored nor should it be subjected to the starvation of bureaucratic controls. Detailed knowledge of the sociology of doctors and patients is needed if our facilities are to be used rationally.

4. The university must play a central role in such planning. Its rich intellectual resources must be made available to the planning group. Hopefully the elements of medical care planning will become a part of the medical school curriculum so that the physician can ultimately contribute to change through planning rather than resist it through fear of the unknown. The relevant disciplines centered in Schools of Public Health should be integral parts of the medical school curriculum and the rationalization of the whole spectrum of health services should be an on-going area of research and teaching within the university.

5. While planning for facilities, the problems of manpower must also be considered. New machinery and new facilities such as hospitals, nursing homes and public health units are useless and even harmful if technical and professional help is unavailable or inadequately trained. The provision of a healthy environment for those who care for the sick is crucial. They should not be harassed and depressed by dismal or inefficient surroundings built by poorly trained individuals. The recruitment of such critically needed manpower is the responsibility of all of us and cannot be delegated to a central authority alone. Doctors can learn much and help considerably in influencing a larger number of each new generation to enter the medical world and work effectively once there; administrators and trustees play a crucial role in their management policies in retaining manpower; local and federal political representatives can help through detailed understanding and support of better and more expensive hospital care while encouraging utilization of lower cost, after-caring facilities. The 89th Congress has shown this understanding through the Medicare and Heart Disease Laws.

In the future, technical facilities will become increasingly important in the application of new knowledge in the care of the sick. Historically, plant and facilities have received short-shrift at the hands of city, state and federal authorities and the subdivision of the tax dollar has always found the hospital at the lowest end of the pole in terms of operating expense and replacement monies. In the era of expanding scientific and technological advance, the teaching of medicine and service to the community cannot be carried out in inadequate existing facilities, to say nothing of the increasing capital expenditures necessary to establish the new medical technology. The building of facilities per se does not guarantee full utilization of new knowledge if planning is inadequate and manpower is deficient. Trustees, community leaders, medical profession and medical faculty must be able to plan rationally so that a public and private system of medical care can combine to advance the frontiers of medicine. If responsible planning on a private, local basis fails, then the voter in desperation will turn to the more distant and more centralized Federal planning — and local initiative and responsibility will wither to the detriment of our national effort to match need and action to produce a better and healthier society.

John H. Knowles, M.D.

Massachusetts General Hospital

INTRODUCTION

Boston City Hospital

Peter Bent Brigham Hospital

Beth Israel Hospital

The third year students now begin their clinical adventure with a concentrated course known as the.....

to the CLINIC

By the late 1950's at Harvard Medical School, major changes in the curriculum of the first and second years were under way.* These were changes directed at unifying the teaching of various organ systems so that the normal physiology and histology of these systems could be studied in sequence with their pathology. Interrelated systems such as the heart and lungs could also be studied coincidentally. Avoidance of teaching overlap and repetition was the ultimate purpose of the change. The new curriculum also made it possible for the student to study an organ such as the kidney in relation to cardiac disease, hypertension, and other interrelated pathological entities. The greater volume of new medical knowledge that appeared on the scene after World War II placed a taxing load on older teaching techniques. The new cohesive system oriented teaching method gave the school and its teachers a way of getting across to the student this new information with the least waste of time and repetition.

Having reorganized the first two years, it was a foregone conclusion that the Curriculum Committee would devote its attention to the two clinical years. Paradoxically, the Curriculum Committee in charge of these two years decided to shorten the total amount of required didactic teaching and to increase the amount of elective work. In order to do this, a compressing action had to be undertaken in the third year. In essence, it meant that more material would need to be covered in a shorter space of time. But close investigation of the old third-year curriculum revealed considerable wastage of time. There was frequent overlapping repetition in the teaching of subjects and often a notable lack of continuity. The curriculum was criticized because of the need for extensive commuting from one hospital to another; from the medical school and back to the hospital. There

*"A Rearrangement of the Curriculum in the Preclinical Years at Harvard," by Manfred Karnovsky. HMAB, April, 1957. Vol. 31. No. 3, pp. 7-11.


Massachusetts General Hospital

It is the first chance to study patients

appeared to be no central organizational mechanism set up to insure adequate coverage of the major clinical subjects and the major specialties. As a result, many students finished the third year with strong knowledge in certain areas and none in others that were equally important. It also appeared that there was considerable similarity between the third and fourth year curricula although the fourth year clinical clerk did assume more responsibility than his third year counterpart. The third year student was becoming more clinically oriented within the hospital framework and in so doing he was stepping over into the fourth year area. Therefore, it was clear that a certain amount of curricula trimming could easily be carried out without losing anything valuable.

The result of this trimming is the third and fourth year curricula noted in Chart 1, which begins in September after the second basic science year:

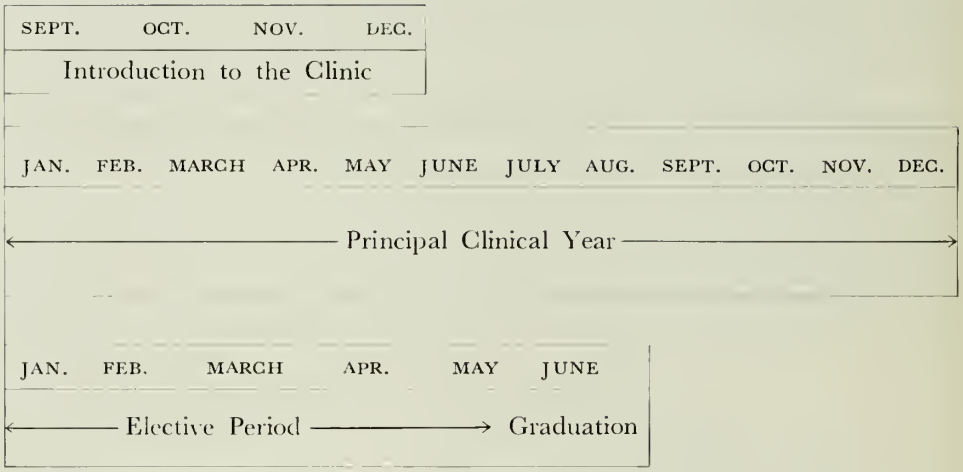
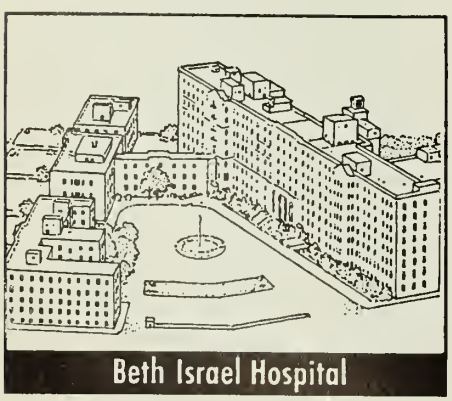


Chart 1

The Introduction to the Clinic, now in its second trial year, comprises a twelve-week course in basic clinical fundamentals. It is the first real chance a student has to see and study a living patient.


Beth Israel Hospital

The Principal Clinical Year, lasting twelve months, is divided into three four-month semesters; medicine, surgery and the specialties. In many ways it is similar to the previous fourth year curriculum which has always been a hospital oriented teaching device.

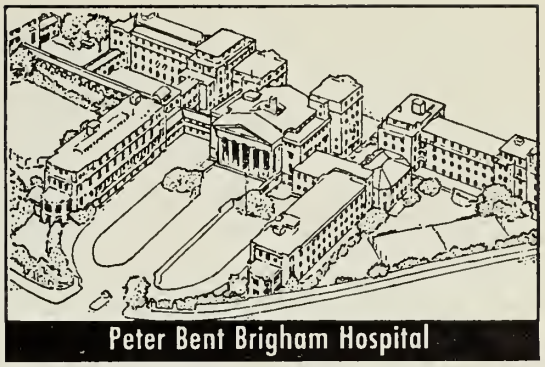
The Elective Period from January in the fourth year to the day of graduation offers each student a chance to fill in gaps in his knowledge in areas of his choice or allows him to extend his initial efforts in research if he so desires.

The first trial principal clinical year has not yet been completed and the first elective period of five months will begin in January of 1966. This present report will confine itself to a brief review of the Introduction to the Clinic.

THE concept of the Introduction to the Clinic has been well received in general by both faculty and students. Its ultimate purpose is to develop in each student the ability to obtain a good history from both outpatients and inpatients, and to focus rationally on a symptom complex. Although it is difficult to separate diagnosis and therapy from such a teaching exercise, disease and diagnosis and therapy are not emphasized in this course.

The third year class is divided into four groups for these 12 weeks that begin in the Fall. Forty-eight students are assigned to the Massachusetts General Hospital, 32 students to the Boston City Hospital, 24 students to the Beth Israel Hospital and 36 students to the Peter Bent Brigham Hospital.

The general format of each week's


Peter Bent Brigham Hospital

Students are stimulated by this clinical experience

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
8- 9:00	(lectures)† ← →					
*9-12:00	students in small groups working at bedside with patients under supervision. ← →					
12- 1:00	(C.P.C.)* (Specialty conferences)† ← →					
2- 4:30	joint med-surg clinics	free	specialty lectures exercises at HMS	free	specialty lectures exercises at HMS	free

Chart 2

( )* — These vary with the hospital
( )† — At one hospital

activities as proposed by the Curriculum Committee is as shown in Chart 2.

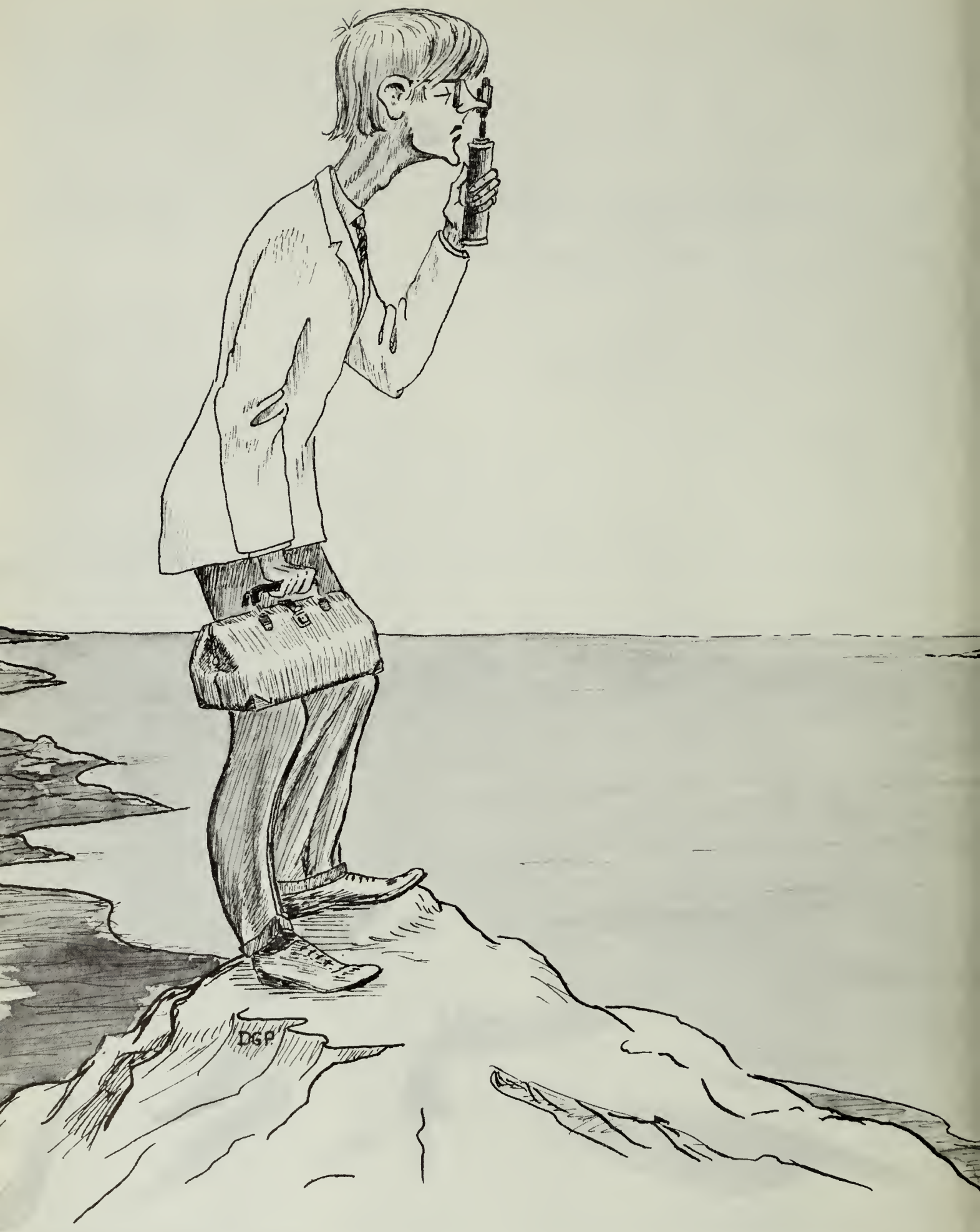
The broad schema applies in each hospital but many lesser variations in day-to-day activities occur within the different hospitals. The primary goal — that of significant contact between the student and a good number of patients at the bedside — has been accomplished. Beyond this, each hospital has devoted varying amounts of time to didactic sessions, lectures, symposia and conferences dealing with the various important subjects in medicine, surgery and the specialties. An attempt to cover all these subjects has been, of course, impossible, and by necessity, certain specialties and certain subjects have been slighted in the course of the 12-week period. Interrelated sessions between medicine and surgery have been emphasized and hopefully some time has been spared for reading and assimilation of this body of knowledge.

It is worth noting that the students look most favorably upon that part of the 12-week session that deals with patient contact. The clinical pathological conference also appeals to them and the patient-oriented symposia on broad subjects such as pulmonary physiology that allow a coordinated medical and surgical approach to disease have also been popular. Medical School students reserve their strongest criticisms for cold, didactic, multiple-slide-oriented sessions. At this time their particular hunger is for clinical material which they can themselves study first hand. Because of the School's large clinical teaching group, it has been possible to assign one instructor to no more than three students. This 12-week period places a significant commitment on the teaching faculty; it creates an intimate contact between the student and the teacher — increasing their knowledge of one another. Such a method allows for a much more productive and imaginative way of learning. Emphasis is placed on careful work-ups and on detailed evaluation of the patient's history, symptoms and physical signs as they mold together to become a logical disease entity.

The Introduction to the Clinic is undeniably a concentrated fare and does leave the student somewhat breathless. Original fears that these "12-week wonders" might not be adequately prepared for the rigors of patient care and therapeusis demanded of them by the Principal Clinical Year have been on the whole unfounded. The knowledge and ability of these relatively "immature" fourth year students who have gone through the first Introduction to the Clinic to us seems to be as satisfactory as that of their original predecessors.

Not all change is for the better, and there is no excuse for change for its' own sake, but as one views the first two years experience with the Introduction to the Clinic, one feels that the course accomplishes a great deal and quickly plunges the eager student into hospital and outpatient life.


Boston City Hospital


DGP

DON'T Judge a DOCTOR by his Coat SIZE

by

Hugh G. Foster, Jr., '67

WHOEVER it was that stood on the lofty peak in Darien for man's first view of the Pacific must have been stout and fearless, mindful of king and country, and in the company of a bright-eyed band of fellows. In these respects, he could not have been very different from his modern counterpart — the third-year Harvard Medical Student.

The virgin healer, or "student doctor" as he is wont to call himself, will probably never discover an ocean. But he does have his own sea of troubles. Even as he faces the treacherous tide of his first clinical experiences, he is struggling to stay afloat in the unfamiliar, dark waters of liver function tests, skiagraphs, and platelet counts. He is inclined to think of the explorers of bygone eras as men, unlike himself, well-equipped for their visionary tasks. After all, they did not bear with them the onerous stigmata of the basic sciences, nor did they have to make the Olympian leap from enzymes, nerve tendrils, and the charivari of microthings to their awesome whole as the human patient. What is more, they were armed.

In the words of Chester Goodheart, HMS III, "Being a neophyte isn't easy." and Chester's steps toward his first patient were predictably wobbly. One might say his gait was 'mincing,' a term he himself would prefer. Insinuating his lithe, seventy-kilogram frame between the modesty curtains about the sick-bed, Chester boldly began a frontal attack straight from page one of the Red Book.

"Good morning, Sir, and how are we today and when did we last feel perfectly well and do we drink much,

A sweet, young lass from South Boston

come-come, you can trust me whose word is sacred, and is there any history of family in our disease and have we ever coughed up any blood in our urine?"

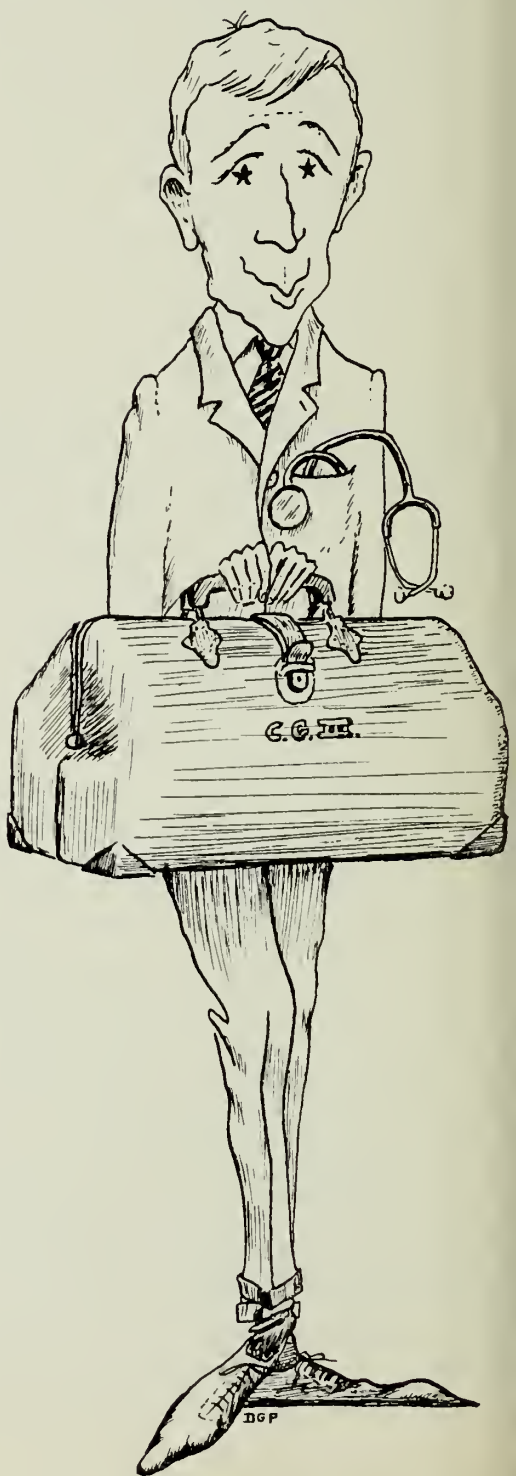
Faced with this onslaught of tender well-meants, the patient was at once put at his ease and prepared for the traditional ritual of the Systems Review. Much has been said for and against the practice of patterning the art of history-taking after the Red Book's checklist. Chester, for one, accepts it as the very breath of Hippocrates and did the great father honor in observing instructions to the letter. The patient's medical history was elicited for every follicle and panniculus. His narration of G.I. disturbances, for example, had for Chester all the mystery of a John Gunther saga. And the mind's eye of our young practitioner painfully examined every fine detail of over two thousand centimeters of lining mucosae.

BUT the Odyssey of the first patient had barely begun. Only when a lengthy work-up is presented to his instructor has the student really done his duty. And it is in this aspect of clinical work, where the glib phrase and the paramedical adjective separate the amateur from the seasoned Harvard healer, that Chester and his mates fully came into their own. Let us examine some exercises from Chester's early writings — his Brigham Papers.

"This is the first PBBH admission for Mr. Bloode Klotz, a thirty-seven year old retired gypsy, father of ten, who enters with the chief complaint of Hirschsprung's Disease, pheochromocytoma, and Ytterbium intoxication. The patient is an eloquent, not to say silver-tongued historian, a swain of Falstaffian habitus and Ciceronian carriage who is observed to have two small puncture wounds over his left jugular vein . . . the patient has a lively, scherzo pulse and a brace of stout lungs; his bellows are stentorian . . . S2 is physiologically cleft . . . at three packs of Luckies per day, he is a confirmed Cheyne-Stoker . . . his fell constellation of symptoms includes a 4-plus lesion with a two-plus heave and the one-plus prognosis led him to be referred to Dr. Thomas Swift (of this staff) for an electric pacemaker. The patient chews Dentyne and has never been arrested . . ."

"This is the fifth PBBH admission for Miss Ego Canis, a twenty-one year old lass from South Boston, who has long red hair down to her shoulders, a

Ready, willing and able!



stately, albeit plumpish visage, and cold feet. She is a charming informer . . . on a recent witches' Sabbath, she discovered a red line across her cheeks, where she wears her Yashmek . . . a potpourri of lab tests from her former admissions establish that her tissues are densely populated by wandering lymphocytes . . . she was weaned at ten months, and since menarche, has suffered from Metternich (Mittelschmerz?) every four weeks. She has a left, or maybe right, ventricular heave and her PMI is in the fifth or seventh interspace somewhere over her left precordium . . . she has primary, or secondary, amenorrhea; she is allergic to the boll weevil . . ."

"This is the first Brigham admission for Don Alvaro, a fifty-seven year old member of the Lisbon court, former alchemist and zymologist to the crown, who enters with the chief complaint of "I am being followed." This man cannot be trusted; in fact, he speaks with a bifid tongue . . . his buccal mucosa is unremarkable but his mien bespeaks great internal suffering. He has butterfly rashes, pneumonitis, fractures, and liver, coffee-ground vomit, clay stools, and there are broccoli-like growths over his left tragus . . . I suggest he be followed, after immediate discharge, with radioactive tracers . . ."

By the time Chester and his classmates had mastered the complex jargon of the clinic, there remained but one last hurdle on the way to the Principal Clinical Year: the CPC. CPC'-manship is a demanding technique and the student doctor must bring into focus all his heavy mental artillery for these exercises in positive thinking. The day finally came when Chester presented the HMS III discussion of a case before the august body of zealots. (Chester's mother has thoughtfully preserved for us his brief remarks at the recent clinico-pathological Cabal).

"Gentlemen, it is a privilege to have this opportunity to present the opinion of the third-year students on this case. We were, first of all, unanimous in praising the surgeon for his miraculous intervention; had he cooled his heels and been less daring in his approach, we feel that the happy outcome of this history might have been otherwise. We find ourselves torn between several diagnoses and think it a tribute to the discusser that he so skillfully presented so many tempting alternatives. We were, finally, divided equally between a fractured head of the left femur and polycythemia vera — with complications. Thank you."

Naturally, there is more to being introduced to the clinic than this: there is canine surgery (The Ages of Dog); the small peanuts of the specialty disciplines like Latinized Dermatology; the daily orthopedic clinics featuring the enticing ballets of the visiting podiatrist. There is the matter of escaping the draft. Finally, there is the unfortunate matter of the student doctor's lacking a name worthy of his talents. He will be "lad" to the senior staff members, "son" to the resident, "mental cripple" to the ward interns. But to his worshipping patient, he will always be "my doctor."

As the student doctor continues to add more pearls of clinical wisdom to his coffers, he will come to discover that, in the end, he must forge for himself the tools of patient care, at the bedside and in the eternal confrontation between the sick and the physician. He will progress to an understanding of Medicine's greatest maxim — in the words of the poet Kuzma Prutkov — "Death is placed at the end of life so that we may better prepare for it."

"I'm being followed."

BIOGRAPHY of a Collective Bargain

by

Paul J. Davis '63

IN the words of the ofttimes tedious Doctor X, the house officer's pay "will vary from nothing at all to a pittance."[1] Within my hearing the now apocryphal story of the heavily-mortgaged resident who placed himself on Welfare has been attributed to prestigious teaching hospitals in Boston, New York and Detroit. Eugene A. Stead, Jr., summarizing academic hospital wage philosophy in 1963, stated that "interns and residents are working in clinical services primarily to further their education . . . the idea of paying them primarily has never been seriously proposed (because) the intern and resident can create more funds by practice than the hospital can collect for their services."[2] Dr. Stead added later, "an educational institution . . . will not seek to pay wages. Any intern or resident working for wages should be given some other title, to indicate that he is employed for service."[3]

Certainly the apprentice system as it was practiced some centuries ago, untrammeled by otherwise pervasive social revolutionary forces, has persisted only in medicine and the priesthood. Hobbled by spiraling costs of living, fecundity and long-term-low-pay training programs, the apocryphal house officer exists, it is said, even outside Boston, New York and Detroit. That there have been fewer such house officers in New York City in the past decade is due to the hiring of a lawyer named Murray Gordon by a group of municipal hospital interns and residents.

In 1958 Murray Gordon was a Lower Manhattan lawyer who said he "was appalled to learn that the most highly-specialized city employees were receiving the city's meanest wage" (interns' salaries were $71 monthly). Today Murray Gordon is still a Lower Manhattan lawyer. He is still appalled and interns are still being paid less than garbage collectors.[4] Primarily through his intercession, however, the Board of Estimate of New York City[5] — a body to whom penury represents the ultimate human virtue — has come to recognize that house officers have to live as well as work.

AN organization known as the Committee of Interns and Residents (CIR) of the New York City Municipal Hospitals hired Murray Gordon in 1958 and it has since trod a narrow

path among hues and cries from elsewhere in the nation of "unprofessionalism" and "tradeunionism." CIR has, in a manner of speaking, collectively bargained with the city for higher salaries without going to court to obtain a collective bargaining certificate.[6] It has dealt out of weakness with union-tested city economists, to whom strike threats and rumors of strike threats are routine, because it has no threats and has recourse only to public opinion media.

Murray Gordon is also lawyer for the firemen and police of New York City. As their representative he has said that "the basis of collective bargaining is being totally unreasonable until the time of settlement, but to appear fair and reasonable." This cynicism has not been extended to CIR. Negotiations with the Board of Estimate have involved for CIR little more than formal summaries of already existing wage conditions among municipal hospital physicians. These statements, in themselves, have been effective indictments of an unrealistic and anachronistic remunerative system.

The policy of the Committee of Interns and Residents has not been to deplore the fact that garbage collectors make more money than doctors. Rather it has emphasized that certain City-employed physicians[7] fail to receive a wage with which they can support themselves and their families. Harry Bronstein, chief budget examiner for New York City, with characteristic baldness, has rebuffed CIR on occasion with the statement that "the City unfortunately does not have a license to print money, and I know in ten years you will all be rich." Nonetheless the City has responded with a lack of customary stinginess to the requests — under no circumstances could they be distorted as "demands" — of the Committee.

CIR began in 1958 when the City announced sotto voce that Social Security payments would be withheld from house officers' salaries, in many cases on a retroactive basis. House officers at the Bronx Municipal Hospital Center (Herbert Vaughan, Jr. and Samuel Switzer) and at Bellevue (Saran Jonas) contacted Murray Gordon at that time. It was obvious to a nonmedical observer that the major issue was not the threatened subtraction of Social Security benefits, but rather the fact that there was almost nothing from which these benefits were to be withheld. The existing salary scale was summarized in an appropriately brief press release and provoked a sympathetic **Times** editorial. A borough president — whose son-in-law was of course a doctor (in the Municipal Hospital system) — indicated strong support for increased house officer wages. At open hearings before the Board of Estimate, Mayor Wagner (discomfited, it is said, by the disclosure that many City Hospital physicians were being paid at the rate of 17¢ an hour) directed the Director of the Budget to negotiate immediately with representatives of the Committee of Interns and Residents. Subsequent negotiations have eventuated in a wage which in many cases forestalls new indebtedness during house staff training. Other benefits have also accrued, including this year a group life insurance program paid for by the City which protects house officers during their tenure and which may be converted to a personal policy, without physical examination, at the conclusion of training.

THE CIR has not created a unilateral system by which the till of an impoverished city is siphoned into the pockets of greedy residents and interns. In 1960 the Committee recommended to the Department of Hospitals a private hospital affiliation program which has recently been realized. It has provided legitimate teaching hospital status for certain private institutions which were formerly of rather dubious stature. Grievances at various levels in individual hospitals also have been handled by the Committee in discussions with the City and the Commissioner of Hospitals.

"Bargaining sessions" with City economists have also provided house officers with a unique insight into the random behavior of SuperGovernment in the UnGovernable City. The narrow minded may object that "eager beaver house officers," as Dr. Stead has termed academic hospital residents, have no business at the bargaining table or at City Hall, away from the amenities of ward rounds. Few professions, however, exist in as complete ignorance of legal procedure as does medicine. Few professions have as short-sighted a conception of the economy in which it operates as has medicine. Few professions are as naïve politically and as impractical sociologically as is medicine. A few hours in the Budget Director's office in the Municipal Building, haggling over several millions of dollars with shaggy-browed, mustached Harry Bronstein, is a sobering experience which places what appears to be an infinite budget and the finite individuals who administer it into perspective.

The ultimate aim of the Committee is self-effacement, effected through achievement of a satisfactory wage and a city government attuned to the needs of individual hospital staffs. That this aim is a fairly remote eventuality is patently clear. Critics of CIR — those who feel that Service in Academia is remuneration enough, that house officers have no business acting as a body politic, that concern of house officers with a living wage is a repudiation of the Oslerian tradition — may take solace from the observation that increased wages have resulted in a decline in interest in the CIR among Municipal Hospital house staff. It seems reasonable to hope, however, that a reasonable wage will finally exempt house officers from carrying into postgraduate training the disquietude of insolvency which contributes not a whit to their stature as physicians.

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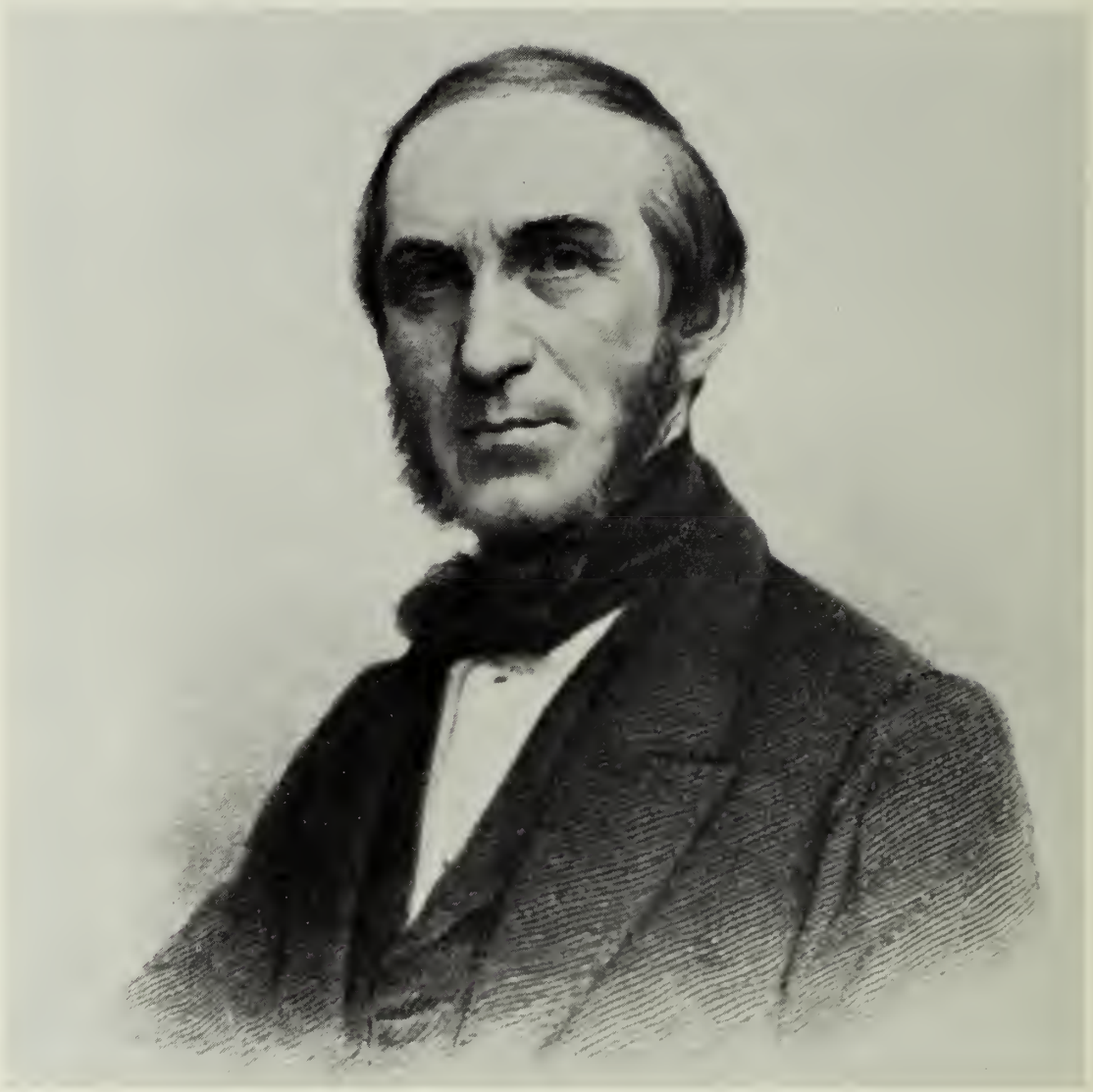
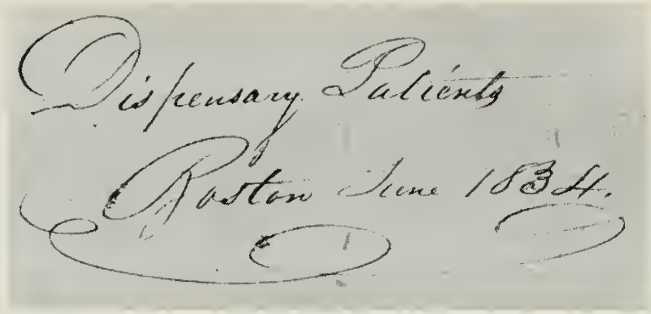
1. Doctor X. **Intern.** New York: Harper & Row, Publishers, 1965, p. 4.
2. Stead, Eugene A., Jr. Medical Care: Its Social and Organizational Aspects. **New England Journal of Medicine, 269**:240-244, 1963.
3. Stead, Eugene A., Jr. Correspondence. **New England Journal of Medicine, 269**:759, 1963. In all fairness to Dr. Stead it must be indicated that he has worked steadily for improved house officer wages (or "scholarships") at Duke University Medical Center.
4. Interns in the City Hospital system now receive $4800 annually; in addition they receive board, full laundry and on-call quarters without charge.
5. Composed of the Mayor, Controller and Presidents of the Boroughs.
6. In order to negotiate contracts with the City, a trade union must present a court-ordered collective bargaining certificate, indicating that the negotiating party represents a significant proportion of the class of City employees it purports to represent.
7. It is unprofitable to argue the legitimacy of applying the term "physicians" to house officers.

The Forgotten Man of the Ether Controversy



by George E. Gifford, Jr., M.D.



IN medical circles whenever mention is made of the ether controversy the three famous names of Morton, Jackson and Warren come to mind. But there was another man, also a Boston physician, who played his own quietly substantial part both before the ether demonstration and later when the bitter controversy arose between Morton and Jackson and raged through the courts. That man was Augustus Addison Gould, M.D.

He was a country farm boy born in 1805 in New Ipswich, New Hampshire. At the age of 17 he entered Harvard College where he became known for his industry and his interest in botany. Although he became a medical student at the Massachusetts General Hospital under the tutelage of James Jackson and Walter Channing, receiving his M.D. degree in 1830, he did not find his medical practice to be very lucrative. Most physicians of his day were financially independent, but Gould was not, and he was forced to work outside the medical profession.

It was only natural with his love and knowledge of botany that when the Boston Society of Natural History was founded in 1830, Gould became one of its first members. A short time after he was appointed "curator" in the Society.

Although today he is best remembered for his work in conchology, the early 1830's saw the 25-year old Gould beginning a pursuit of several careers — physician, author, editor, teacher and conchologist. Soon after becoming "curator," he catalogued and classified 50,000 pamphlets in the Boston Athenaeum, and for that massive work, done in four volumes, he received the diminutive sum of $50!

1833 was both a productive and varied year for Gould. He married Harriet Cushing Sheafe and the two lived in one of a row of Bulfinch houses, that faced Boston Common at 194 Tremont Street, known then as Colonnade Row but, unhappily, no longer in existence. That year he gave one of the lecture courses offered by the Society of Natural History and he published his first work on conchology, *Lamarck's Genera of Shells.* About this time with A. L. Pierson, J. B. Flint and Elisha Bartlett he edited the *Medical Magazine* which was published in Boston between 1832-1835. During 1834 he served in the Boston Dispensary, and for two years he taught botany and zoology at Harvard College.

Above left: Augustus Addison Gould, 1805-1868.

Right: The original ether apparatus used by Morton at the Massachusetts General Hospital.

Gould's Wedge. This little bivalve lies in the sand close to shore. It is extensively gathered, despite its small size, for making soup. (Found from San Luis Obispo, Calif., to Mexico.)

It was not until 1840 that Gould began to work significantly with conchology. That year he described 13 new species of shells in Massachusetts. These were only the first of a total of some 1100 new species described by him before his death. That same year he noted that Cape Cod was a barrier to northern and southern species of shells. He described the phenomena in a paper with the lengthy title of, "Results of an Examination of the Species of Shells of Massachusetts and Their Geographical Distribution." A year later he gained his international reputation with his report on the *Invertebrata of Massachusetts*, which he illustrated himself.

HE was now a leading American conchologist and by 1846, Gould had begun work on his report of the shells found by the famous 1838-1842 Wilkes Expedition. It was in the late summer of that medically significant year that Gould first met a tall, handsome, red haired, dentist named, William T. G. Morton. The 27-year-old Morton called on Gould to request permission to place Gould's name as a reference on his professional card. It seems that Gould readily agreed to let Morton use his name as a reference. One supposes that his readiness was due to the fact that Gould had already heard about Morton from his close friend, Dr. C. T. Jackson who was, in fact, Morton's medical preceptor. Gould and Jackson were close associates and must have met one another frequently. Not only were they both physicians and part of the small, tightly knit medical community but Jackson was also a geologist and fellow member of the Boston Society of Natural History.

It is easy to imagine that when Gould and Morton first met they found they had much in common with one another. Morton was also deeply interested in natural history, neither of them was a rich man's son, both were industrious and inquisitive about nature, and both felt compelled to try, each in his own way, to lessen human suffering.

Gould, of course, had already established his professional reputation in Boston and he was known also to be a genial, kindly physician and friend of many of the medical leaders of the time. Morton, on the other hand, was practicing dentistry and comparatively unknown in the medical world. Undoubtedly, Morton was a persuasive talker as well as being a man with a great deal of ambition. He had attended lectures at Harvard Medical School, and had, by his own admission to Gould, a driving urge to find a way to relieve pain for his dental patients.

When the two first met, Morton was lodging in Jackson's house but he was unhappy there as apparently he had trouble getting along with Jackson. It is probably that even during their first meeting, Morton discussed the question of new lodgings with Gould, because a few weeks later Morton, his wife and infant son moved into Gould's house to become "part of the family."

There is no evidence that Morton discussed his secrets about ether before he moved into Gould's house but shortly after the move Morton confided to him, "I will have some way yet, by which I will perform my operations without pain." Gould replied that if he could effect that he would do more than human wisdom had yet done, or that he expected it would ever do. It was Gould's wife who first told her husband "at the dinner table" that Morton had performed the first few dental extractions under ether.

Sometime during the month of September, Dr. Henry J. Bigelow, a visiting surgeon at the Massachusetts General Hospital, having read of Morton's painless operations in a newspaper advertisement, became anxious to watch one of the operations. Bigelow did not know Morton but when he found out that Morton was lodging with his old friend Gould, he asked Gould to get Morton's permission for him to watch a dental patient undergoing anesthesia. Morton gave his consent and Bigelow promptly made his own clinical observations and kept notes.

Certainly Bigelow was instrumental in persuading Dr. John C. Warren to try Morton's preparation, because on October 4 or 5, Warren asked Morton to call on him at his house. The 68-year old Warren, surgeon-in-chief at the Massachusetts Hospital, must have been impressed by what 27-year old Morton told him about painless tooth extractions for he agreed to allow Morton the opportunity to try ether at the MGH on one of his own patients.

OF this period Gould later stated, "While he (Morton) boarded with me . . . during its (ether) earliest administration he was overwhelmed, day and night, conducting the administration and introduction of ether. He became very nervous and lost strength."

Under such stress Morton needed an ally and he found one in Gould. On the night before the famous demonstration of ether at MGH Gould and Morton spent several very important hours together. Gould wrote the following description of what transpired:

"The evening previous, Dr. Morton, whose office was opposite to me, called to ascertain about the probable injurious effects of ether, and what articles might be used. I answered; and in the course of the conversation I asked him how he gave it. He told me that he put a sponge in a globe saturated with ether, and drew the vapors through a tube attached; breathed out and in through a tube attached. I suggested that the application of valves, to prevent breathing back the air into the globe, would be desirable, and sketched a plan. He said, 'that is it; that is just it. I will have it for tomorrow.' I advised him not to attempt it, but to use what he was sure he would succeed with. He then left me. He took the plan which I had sketched away with him.

"I went to the hospital the next day at the appointed hour. Dr. Warren was about to com-

mence the operation. He suddenly rose and turned to those present and said he had forgotten that he had promised to allow Dr. Morton to give something which he thought would prevent pain, and he would wait. In about ten minutes Dr. Morton appeared with an inhaler, with valves, such as I had proposed. He administered the ether. All looked incredulous, especially as our man at first became exhilarated, but suddenly the anesthetic effect took place. This occasioned a start of surprise from all present. Dr. Morton coolly informed Dr. Warren that his patient was ready. The operation was performed, which was the removal of a tumor from the jaw.

"I recollect one other incident. Previous to the operation, Dr. Warren, having waited ten or fifteen minutes again turned to those present and said, 'as Dr. Morton has not arrived, I presume he is otherwise engaged,' apparently conveying the idea that Dr. Morton did not intend to appear. The remark of Dr. Warren's brought out a great laugh. Dr. Warren then sat down to his patient. Just as he raised his knife Dr. Morton appeared."

Morton's own account of the same night is collaborative:

"When the time drew near for the experiment at the hospital, I became exceedingly anxious and gave all my time, day and night, hardly sleeping or eating, to the contriving of my apparatus, and general investigation on the subject. I called on Dr. A. A. Gould, a physician who has paid much attention to chemistry, and told him my anxieties. He sympathized with me, gave me his attention and we sat up nearly all night making sketches of apparatus. He first suggested to me an antidote in case of unfavorable effects and the valvular system, instead of the one I used."

As a supporter of Morton, the only medical man in a group of surgeons and not on the staff of the MGH, Gould must have felt keenly the dour Warren's sarcastic comments. No doubt he waited anxiously for Morton to arrive and wondered if his designs were indeed holding up Morton — who, he knew, was dealing with Mr. Chamberlin, a "stubborn" instrument maker who would not be hurried. And he must have shared with Morton relief when the patient, Gilbert Abbott, sank into unconsciousness smelling the ether, disguised by oil of orange, through the valves designed by Gould.

As the effect of ether was established Morton turned more and more to Gould for advice and help. Gould recalled:

"He (Morton) consulted me after having administered it several times, but not about administering it, except on the evening previous to the operation at the hospital. On several occasions, when unpleasant effects followed the use of ether, I was called upon by Dr. Morton, or persons in his office, to advise what was to be done to relieve the effects of it.

"I was called to six or eight patients. One was in a state of very high excitement, almost a maniac; she was brought to my house, and was unable to go home for several hours. She was in a very highly excited state for several days afterwards, somewhat hysterical. She afterwards suffered in a singular way from a second operation. Some others vomited profusely. One or two were lethargic, and roused with great difficulty. These were the principal phenomena which I recollect."

Gould also helped Morton in other than medical ways:

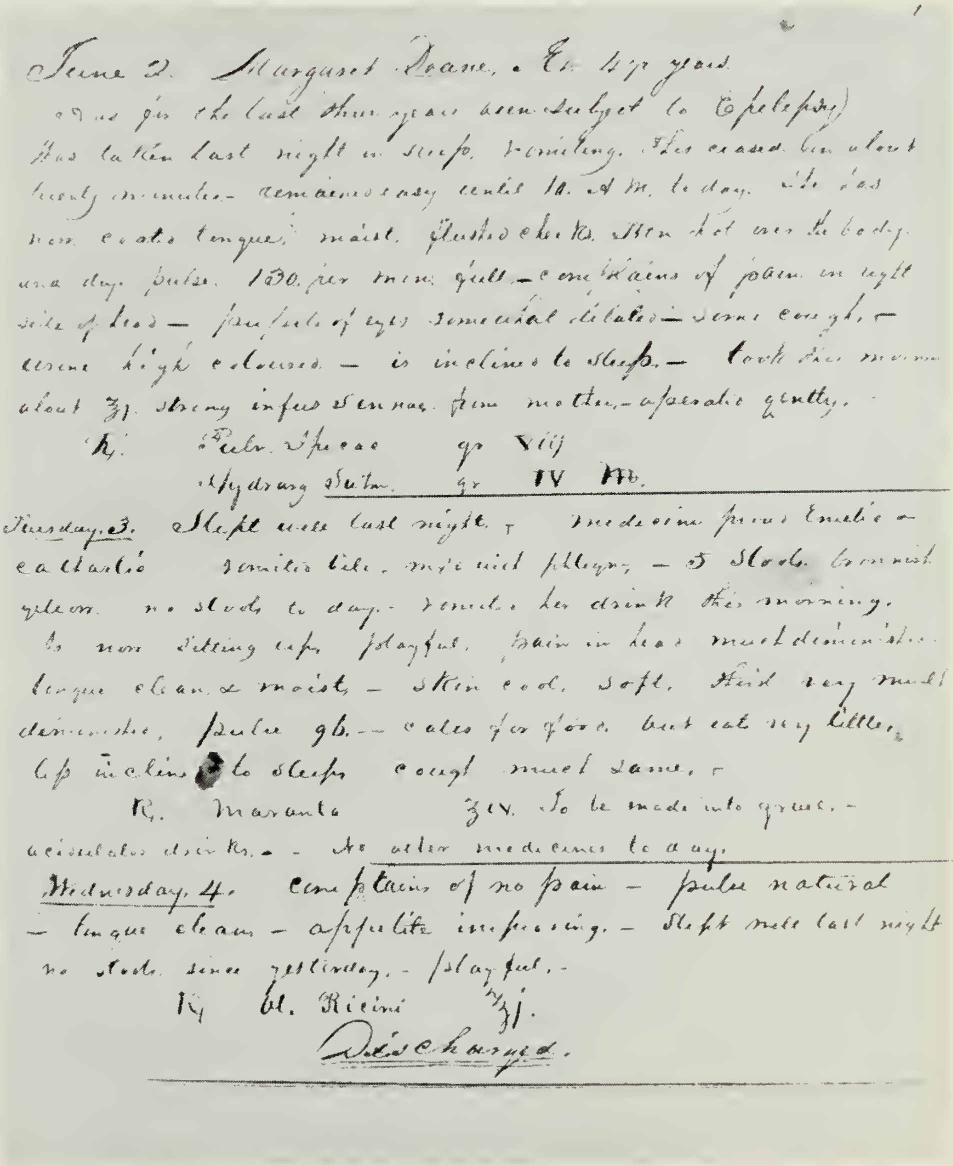
"There were advertisements (in the Boston newspapers), and I frequently wrote them myself at his (Morton's) request. They announced that he was employing a compound recently invented, by which he could perform dental operations without pain. Not being accustomed to writing himself, from lack of early advantages, and being a resident in my family, he requested me to put in form his advertisements. This I did, in such language as he dictated, as his amanuensis, and oftentimes not as expressing my own opinion . . ."

WHAT was the new preparation to be called so as not to give the secret away? On November 20, Morton and some friends met at Gould's house and Gould, it is said, suggested Letheon, from Lethe, the mystical river, a sip of whose waters subdued all hurtful memories.

After the successful operation under ether, as everyone knows, Dr. C. T. Jackson, Morton's old preceptor, claimed the discovery of the anesthetic properties of ether. Gould now found himself placed in the role of arbitrator. Warren recollected in his, *Etherization, with Surgical Remarks,* 1847, that "a few days after these first operations I was informed by Dr. C. T. Jackson, a gentleman well known for his chemical and philosophical attainments, in a conversation which took place between him, Dr. Augustus Addison Gould (the naturalist) and myself, that he first communicated to Dr. Morton the inspiratory ether as a means of preventing the pain of operations on the teeth."

Throughout the subsequent bickering Gould acted with moderation, trying to reason with Jackson and control Morton's temper. He remembered one incident, "I was anxious

Gould's medical journal while at the Boston Dispensary, 1834. From the collection of Richard I. Johnson, Museum of Comparative Zoology, Harvard.


June 2. Margaret Deane. Et. 4 yrs.
Has for the last three years been subject to Epilepsy)
Was taken last night in sleep, vomiting. This ceased in about twenty minutes — remained easy until 10. A.M. to day. She has now coated tongue, moist, flushed cheeks. Skin hot over the body and dry, pulse 130 per min: full — complains of pain in right side of head — pupils of eyes somewhat dilated — some cough, — urine high coloured — is inclined to sleep. — took this morning about ℥j strong infus. Sennae from mother, — operated gently.
R. Pulv. Ipecac gr viij
Hydrarg. Sub. gr IV M.
Tuesday, 3. Slept well last night. medicine proved Emetic & cathartic — vomited bile, mucus and phlegm, — 5 stools, brownish green. no stools to day. — vomited her drink this morning. Is now sitting up, playful. pain in head much diminished. tongue clean & moist, — skin cool, soft. thirst very much diminished, pulse 96. — calls for food, but eat very little, [illegible] inclined to sleep. cough much same, —
R. Maranta ℥iv. To be made into gruel. — acidulated drinks. — No other medicines to day.
Wednesday, 4. Complains of no pain — pulse natural — tongue clean — appetite improving. — Slept well last night no stools since yesterday. — playful. —
R. Ol. Ricini ℥j.
Discharged.

Morton making the first public demonstration of etherization at the MGH, October 16, 1846. Physicians around Gilbert Abbot are, from l. to r.; H. J. Bigelow, A. A. Gould, J. Mason Warren, J. Collins Warren, W. T. G. Morton, Samuel Parkman, George Hayward, S. D. Townsend. From a steel engraving published in "Trials of a Public Benefactor," by Nathan P. Rice, M.D., 1859.

that the discourse should not be renewed, and trod upon Morton's toes." Gould stated that he had been "on as intimate terms" with Jackson as with anybody. He pointed out to Jackson that the rules of the Massachusetts Medical Society forbade members to deal in secret remedies. Even though Gould tried to be peacemaker throughout the controversy, the battle raged on until after his death in 1866. He is, however, one of the few who acted with honor and dignity.

AFTER the ether controversy of the 1840's Gould went on to become a leading Boston and American conchologist. Louis Agassiz came to America and became a professor at Harvard in 1848, he and Gould wrote *Principles of Zoology.* In 1847, Amos Biney, a friend of Gould's died leaving in manuscript form, *The Terrestrial Air-Breathing Mollusks of the United States.* Gould finished the work, the drawings for which were done by the celebrated Dr. Joseph Leidy. The result in 1851 and 1857 was one of the most artistic monographs in American science. His last great work was the description of shells from the North Pacific Exploring Expedition (1853-1856). Gould described nearly 1100 new species of shells. His era has been called the Gouldian era of conchology. For these labors he was elected to the Academy of Arts and Sciences and the American Philosophical Society. Eponymously he is remembered by five shells: Gould's Bubble, *Bulla gouldiana* (Pilsbry); Gould's Dove Shell, *Mitrella gouldii* (Carpenter); Gould's Pandora, *Pandora gouldiana* (Dall); Gould's Thyasira, *Thyasira gouldii* (Philippi) and Gould's Wedge, *Donax gouldii* (Dall). Recently his conchological work has been presented in a monograph by Richard I. Johnson.

Gould achieved honor in medicine. He was a visiting physician at the Massachusetts General Hospital from 1857 to 1866 and president of the Massachusetts Medical Society from 1864 to 1866. But perhaps the greatest good this man did medically was helping Morton to develop ether as an anesthetic agent. It seems strange, therefore, that medical historians have dealt with him so poorly. For example, in the classic *Dictionary of American Medical Biography* by Kelly and Burrage, 1928, we read, "Dr. Gould should be given credit for befriending W. T. A. Morton when he was introducing surgical anesthesia in the fall of 1846. Morton lived across the street from Gould, and the latter was instrumental in getting opportunities for Morton to anesthetize when the popular and professional prejudice against etherization was strong." He was of course Gould's boarder. We are subjected to the breathless prose and an array of error in Rachel Baker's *Doctor Morton,* 1946,

and Thomas E. Keys, who wrote the standard work, *The History of Surgical Anesthesia*, 1963, has misidentified Gould in the Rice engraving (fig. 131). There is one enlightening description of Gould made by Dr. William H. Welch, the famous Johns Hopkins pathologist and medical historian, in his letter to Miss Gould. In 1908 Welch had visited Boston to give the Ether Day Address; he met Miss Gould and later wrote her the following letter:

807 Saint Paul Street
Baltimore, Oct. 31, 1906

My dear Miss Gould:

The meeting [with] you at the ether celebration is a pleasant remembrance of my visit to Boston, for I have always held your father in the highest esteem as a representative of the best type of the naturalist and physician. He was probably in closer relations with Morton at the time of the discovery celebrated on October 16th than anyone else, and better acquainted with all the matters which became the subject of controversy. Knowing as I did, him and his character, I have felt that his statement and judgment were of the greatest weight, and indeed decisive. He was of material service to Morton by his advice in many ways, and it is true that the name "letheon" was suggested by your father at a meeting at his house. If in my address I had entered into historical details, I should have had occasion to mention your father, and I may do so if I revise the address, but I touched only upon the broader aspects to paint their value . . ."

With kindest regards, I am,

Very sincerely yours,
WILLIAM H. WELCH

After sifting all the evidence we see that Gould played many roles in his life. He befriended Morton and took him into his home; he undoubtedly helped to arrange for the first ether demonstration; he shared the secret of ether as a anesthetic agent; he helped to design the original apparatus; he gave medical care to some of Morton's first patients; he wrote advertisements; he suggested the first name "letheon" and he acted as mediator between Jackson and Morton. In all these roles he acted with dignity, selflessness and without claims or avarice, a gentle man deserving the title of "The Forgotten Man of the Ether Controversy."

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7. William Welch's Letter to Miss Julia A. Gould was tipped into Ether Day Address. From Warren Collection, Harvard Archives.

Bulfinch's Colonnade Row. From *The Book of Boston*, by Marjorie Drake Ross, 1961.

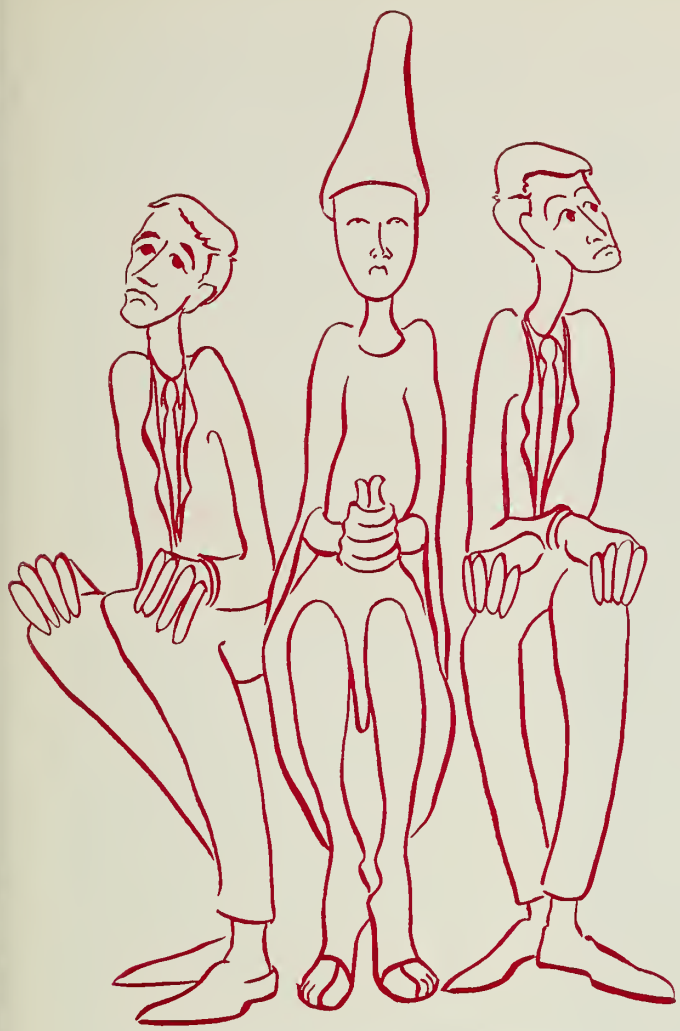
THE SIND STORY

by HMS '66 - '69

"The Admission Committee feels you'd do better in a smaller school."

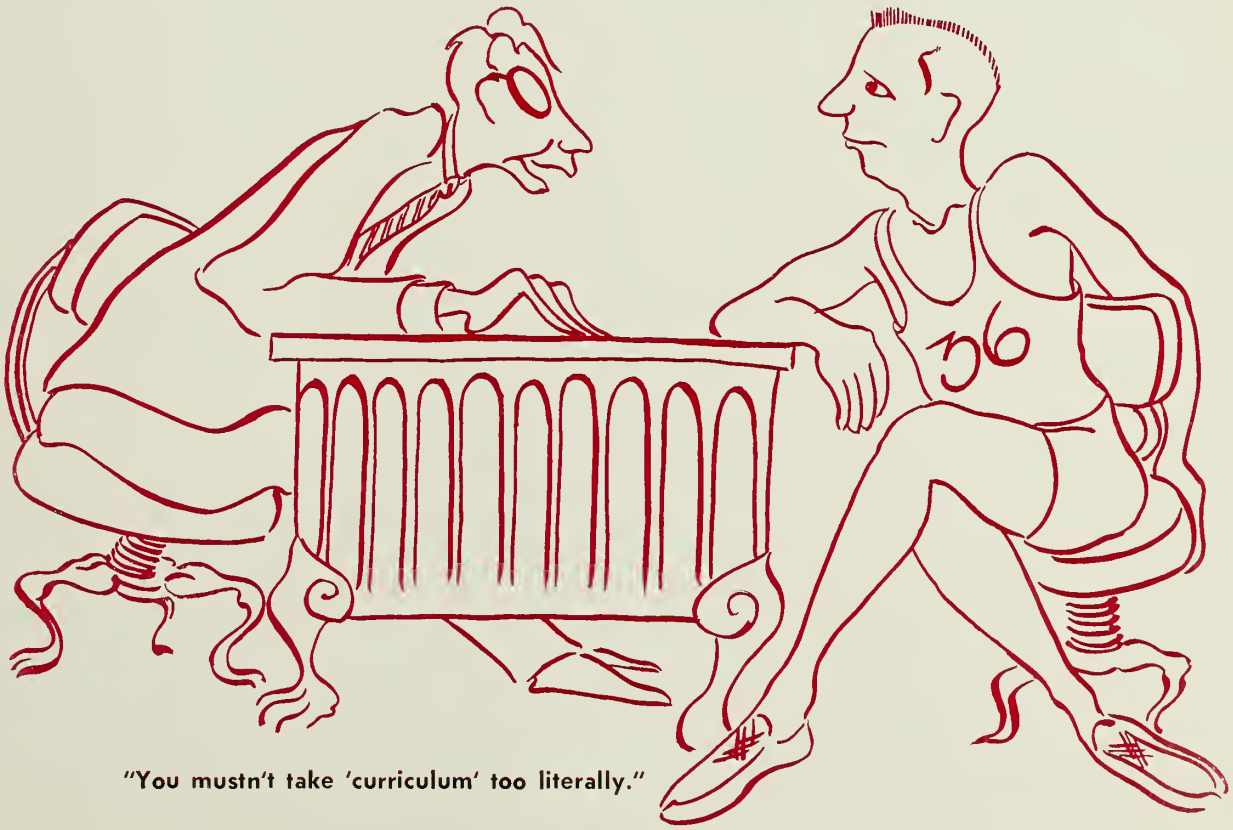
"Oh yes! I remember your father now."

"We don't consider bone throwing a useful diagnostic technique."



"The most likely applicants are invited for interviews."

"You say you've already heard from 84 schools?"



"You mustn't take 'curriculum' too literally."

ALONG THE PERIMETER

Jerome Pollack

New Associate Deanship Established to Study Economics of Medical Care

A new deanship has been created in the Harvard Medical School. On September 1, 1965, Dr. Ebert appointed Jerome Pollack Associate Dean for Medical Care Planning at Harvard Medical School.

It will be Professor Pollack's responsibility to develop within the Medical School a center of interest in the economics of medical care. He will also undertake a study of the Boston community in relation to its medical care needs and how the programs of the School and its Associated Teaching Hospitals should develop to best meet these needs.

Since 1942, following his graduation (B. S. degree) from City College of New York and further study at George Washington University and the University of Chicago, Professor Pollack has been concerned with a variety of study programs in the medical socio-economic area.

From 1942 to 1949, Prof. Pollack served as statistician in the office of the director of research, Railroad Retirement Board. There he compiled and analyzed statistics for both current and long-range studies in the retirement, survivor and disability benefits provisions of the Railroad Retirement Act. Following this he became program consultant, Social Security, United Automobile, Aerospace and Agricultural Implement Workers of America (1949-1962) and (1949-1954) served concurrently as consultant to Kaiser Motors-United Auto Workers Social Security Fund. In the former post Prof. Pollack was responsible for the development of prepaid medical care and other benefit programs including a Community Health Association. At the close of his association with the latter group he developed a program of preventive and rehabilitation health services.

At Columbia University where he served as professor of administrative medicine from 1962 to 1965, Prof. Pollack taught courses concerned with medical care programs, problems and administration. For 15 months he also served as executive director of the New York Labor-Management Council of Health and Welfare Plans, Inc., a joint endeavor to develop a tri-partite corporation with equal representation of labor, management and medicine.

From May 1964 until his appointment to Harvard, Prof. Pollack was executive director of a committee appointed by New York Governor Nelson A. Rockefeller and chaired by Marion B. Folsom, former Secretary of the U. S. Department of Health, Education and Welfare, to study the costs of hospital care within the state and to formulate recommendations on how these costs may best be met. The Committee's preliminary report was issued in April, 1965.

Prof. Pollack also has held numerous consulting posts on major private, state and national groups concerned with health and welfare activities. He was among those who presented papers at the Lowell Institute Lectures of the Massachusetts General Hospital. He is a member of the American Public Health Association, American Statistical Society, American Academy of Political and Social Science, and the American Committee, International Society for Rehabilitation of the Disabled. He has served as a member of the Board of Trustees of the Michigan Medical Service (Blue Shield), the National Health Council, and the Group Health Association of America.

William Sweet Named Professor of Surgery

William H. Sweet '36 has been appointed professor of surgery at the Massachusetts General Hospital. Dr. Sweet is co-director of the basic and clinical research programs in Harvard's Cyclotron Biomedical Building, and

chief of the neurosurgical service at the Hospital.

Dr. Sweet's research interests center on the use of radioisotopes in clinical experimentation. By using a number of radioactive substances, he has studied the formation, flow and absorption of cerebrospinal fluid. He has also used radioisotope-labelled compounds in the diagnostic localization of brain tumors. His use of "coincidence counting" in conjunction with the employment of positron-emitting isotopes has greatly improved the precision of information as to the size, shape and source of radioactivity.

An outgrowth of these studies is Dr. Sweet's current research into the methods of treating intracranial neoplasms by locally delivered irradiation. He has found that by using boron to capture thermal neutrons in the region of the tumor, high doses of short-trajectory alpha particles are produced locally following the capture reaction. This approach has had definite therapeutic effects in certain tumors.

Dr. Sweet is an "effective and stimulating teacher" at the Medical School and his impact is being increasingly felt by students who today have a greater exposure to neurosurgery than they did a few years ago.

Dr. Sweet

Dr. Glimcher

Melvin Glimcher Now Ashley Professor

Orthopedic surgery is entering a period of striking and fundamental change. And the man who will direct Harvard's endeavors in this broadening field is Melvin J. Glimcher '50, recently appointed the first Edith M. Ashley Professor of Orthopedic Surgery. Dr. Glimcher also was appointed head of the Harvard Medical School's department of orthopedic surgery at the Massachusetts General Hospital. At the Hospital, he is chief of the orthopedic service, head of the orthopedic research laboratories, and Albert A. List Research Investigator.

Although orthopedic surgery will be retained and advanced as a therapeutic specialty, under Dr. Glimcher's guidance, it will move into a broader sphere where both research and clinical care will be focused on the physiology and pathology of bone and its associated tissues. The broader area will encompass the response of bone to both metabolic and mechanical stress.

Dr. Glimcher's major research efforts have been devoted to studies of the physical chemistry of bone formation. He was able to produce a precipitate of hydroxyapatite crystals in reconstituted collagen fibrils under acellular conditions in vitro, which resembles the mineralized collagen matrix of bone so closely as to be indistinguishable from it. He has also been investigating the interaction between phosphate and collagen and has gained new insight into the process of inorganic orthophosphate binding.

For his outstanding research in orthopedics, Dr. Glimcher received the Kappa Delta Medal and prize of the American Academy of Orthopedic Surgery in 1959. He is a diplomate of the National Board of Medical Examiners, and a member of the Orthopedic Research Society, the Electron Microscope Society of America and the Biophysical Society.

The Ashley Chair was established by Harvard University in 1961 through a gift from the Edith M. Ashley Fund of the Permanent Charity Fund Inc., of Boston. Under the terms of the gift the initial incumbent of the Chair was to be in the field of orthopedic surgery at the Massachusetts General Hospital.

George Cahill Made Associate Professor

George F. Cahill, Jr. has been promoted to associate professor of medicine at the Peter Bent Brigham Hospital.

Dr. Cahill, who has been director of the Elliott P. Joslin Research Laboratory since 1963, directs his research activities toward the solution of the primary defect in diabetes mellitus. He and his associates have discovered that mild diabetes may provide a selective advantage to a person undergoing intermittent starvation and refeeding by sparing carbohydrate utilization. This, in turn, spares glycogen reserves and minimizes gluconeogenesis from body protein.

Concurrently with this diabetic research, Dr. Cahill has been studying mechanisms whereby the kidney alters ammonia production as a response to acidosis. His studies indicate that gluconeogenesis in the kidney may be the primary controlling mechanism. Dr. Cahill was the first to show that glucose freely diffuses across the liver cell membrane. He was also the first to demonstrate clearly the role of glucose

as a precursor for glyceride-glycerol in adipose tissue and thus for the maintenance of the balance between fat in its storage and transport forms.

An honor graduate of Columbia College of Physicians and Surgeons in 1953, Dr. Cahill has been associated with the Medical School since 1955. In 1962 he was appointed assistant professor of medicine. He received the Ernst Oppenheimer Award — The Endocrine Society's highest honor for a young investigator in 1963, and this year received the Lilly Award from the American Diabetes Association.

S & H Gift

The Sperry and Hutchinson Foundation, Inc. recently presented an unrestricted gift to Harvard Medical School which establishes the S&H Foundation Fund.

In accepting the gift, Dr. Ebert commented that "the unrestricted nature of the grant is especially valuable when so much support, both Federal and private, is directed to specific, short-term research projects. Funds from the private sector are absolutely vital to balance Federal funds if the leading medical centers are to preserve their vitality and independence."

Walter Bauer Fund

The Helen Hay Whitney Foundation of New York has given $50,000 to establish the Walter Bauer Scholarship Fund at the Harvard Medical School. The Fund honors the late Dr. Bauer who was Jackson Professor of Clinical Medicine and chief of medical services at the Massachusetts General Hospital.

The Whitney Foundation was established in 1947 to stimulate and support research on rheumatic fever and rheumatic heart disease. Dr. Bauer was chairman of their scientific advisory committee for many years and vice president of the board of trustees. The Foundation hopes that those who receive scholarship funds will "exemplify the qualities of character and personality that made Dr. Bauer so widely beloved and admired."

Development Office Established at HMS

Recently a full-time Development Office was established in the Medical School as part of the Office of the Dean. It is headed by Bayley F. Mason, who has been appointed Assistant to the Dean of the Faculty of Medicine for Resources. Mr. Mason will direct the development efforts of the Harvard Medical School with emphasis on raising capital funds for new facilities in the Quadrangle as well as support for the preclinical and clinical Faculty.

Mr. Mason served for five years as Assistant Manager and Director of Public Relations for A Program for Harvard Medicine. He received the A.B. degree (cum laude) from Harvard College in 1951.

Dudley M. Todd, who was the New England Manager for the Program for Harvard Medicine's Alumni campaign, is Associate Director of the new office. Miss Jean M. Ballard, Miss Beverly Bennett and William W. Mercer have been named Assistant Directors of Development. Miss Ballard and Miss Bennett were associated with the Program. Mr. Mercer has recently come to Harvard from the Southern New England Telephone Company in New Haven.

The Program for Harvard Medicine, which will close its books on December 31, is only $200,000 short of its $58 million goal. This was the largest campaign ever undertaken primarily for faculty support. The development office will continue the work begun by the Program and further extend development activities.

The newly installed hyperbaric chamber in the Children's Hospital, Boston, looks much like a deep sea sphere. Standing outside the chamber, on the day of dedication, are Drs. William F. Bernhard, clinical associate in surgery and head of the chamber's surgical team, Robert E. Gross '31, William E. Ladd Professor of Child Surgery and guest speaker, Helen Taussig, president of the American Heart Association.

First Lady of HMS

When the Harvard Medical Alumni Council met last month they made one decision, among others, that was unique and will undoubtedly delight Alumni. Miss Dorothy Murphy, known to all as either Dot, Dottie or Dorothy, was made an Honorary Alumna. This is a distinction made to very few, and Miss Murphy is the first woman who is not an M.D., to receive the honor.

At the same time the Council voted to change Miss Murphy's title of Executive Secretary to that of Associate Director of Alumni Relations.

As soon as the Council had made the decisions Miss Murphy was recalled to the meeting. She received the ovation in her own way by borrowing James Jackson's hat, and with a flourish and a bow, she said: "After all these years, among so many men, I am happy to greet you on an equal basis!"

Dorothy A. Murphy, H.A.

Ether Day Celebration Leaves MGH Breathless

For the patients in the Massachusetts General Hospital, October 16th was just another ordinary, busy Saturday. Few of them would have known it was the 119th anniversary of pain-free operations, or, as all MGH House Pupils call it, Ether Day.

This year the MGH House Pupils Alumni Association held their reunion on October 16th, and a busy, memorable day it turned out to be.

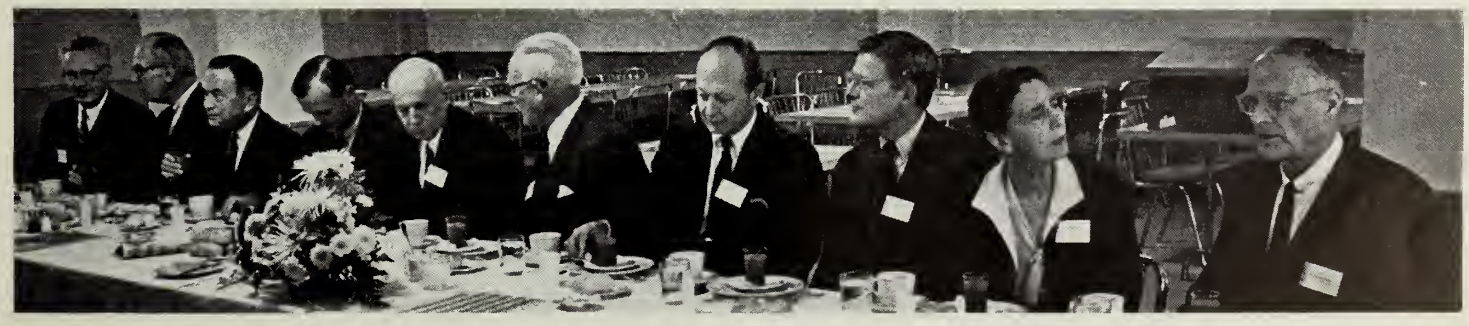
Dr. Langdon Parsons '27, presided over the business meeting. He announced that Dr. Edward D. Churchill '20 had been chosen by the House Pupils Association to receive the Hospital's Treadwell Award. Dr. Churchill is only the third person to receive the award which is given to "an outstanding graduate of the Hospital's internship-residency program." During lunch Dr. Churchill heard Dr. Parsons read the citation for his "thoughtful and imaginative application of physiological principles to the management of surgical problems revolutionized thoracic surgery and profoundly influenced the teaching of surgery in general."

Dr. Ebert, chairman for the scientific program, outlined the current work and future plans of the cardio-pulmonary unit. Before becoming Dean, Dr. Ebert had been the principal investigator of the unit, which is now housed in the new Harold Whitworth Pierce Research Laboratory. During the morning, five papers and a film were presented, all dealing with cardio-pulmonary diseases.

Before lunch all the guests gathered in the sunshine on the Bulfinch Terrace to hear Dr. John H. Knowles, director of the hospital, with Dr. Ebert, officially dedicate the Pierce Laboratories. A new cyclotron, soon to be in operation, is housed in the specially constructed basement of the Laboratory.

During lunch Dr. Knowles' stimulating and vigorous speech delineated some of the hospital's immediate and distant future plans. He likened the problems and opportunities in the medical microcosm to those of the world at large. "We have never lost sight of the fact that our first function is the care of the sick," he said, "but we also realize that to do this optimally demands that active teaching and research be present." Dr. Knowles reviewed several of the more recent research and teaching programs now in operation and he paid special tribute to the role HMS plays in these at the MGH. He also brought out the fact that the MGH is the State's third

The elite eat



Bulfinch's Ether Dome, from the top and the bottom

largest employer of personnel. This automatically places on the hospital authorities certain added responsibilities in their dealings with many governmental departments of the City and State.

Dr. Paul S. Russell, John Homans Professor of Surgery and head of the department of surgery, described the new 14-floor surgical and special services building which is already underway. "The new building will bring together in a centralized fashion all the operating facilities for the entire hospital for the first time in 50 years," he said.

Dr. Oliver Cope '28, professor of surgery and visiting surgeon at MGH, described another new building, to be known as the Shriners Burns Institute, Boston Unit. "In the Christmas week of 1962 the Trustees of the Shriners Crippled Childrens' Program approached the MGH about the possibility of founding a Burns Institute in collaboration with the Hospital," said Dr. Cope. "The Shriners were contemplating enlarging their program for sick children and had been advised by their medical board that burns was an area needing research as well as patient care. They proposed to the MGH that they build an institute next door to the Hospital and that Harvard and MGH staff it. The Shrine have obtained an acre of land from the Boston Redevelopment Authority. Detailed plans for the building have been drawn by the Shrine's architect, Ellerbe and Company of St. Paul, Minnesota with the collaboration of the MGH staff, Judge Wilson and the Building Committee of the Shrine". It is anticipated that the completed Institute will be a reality in approximately two years.

One of the highlights of this busy day came when everyone assembled in the beautifully reconstructed and newly decorated Ether Dome to witness the unveiling of the plaque "designating the Ether Dome in the Bulfinch Building as a Registered National Historic Landmark."

Mr. Edwin W. Small of the National Park Service presented a certificate to Dr. Knowles on behalf of the Secretary of the Department of the Interior. Mr. Small said, "Both the certificate and the plaque specifically indicate that the Ether Dome possesses exceptional value in commemorating and illustrating the history of the United States of America."

The final speech of the day was given by Dr. Henry K. Beecher '32,

Dr. Ebert and Dr. Knowles dedicate the Pierce Laboratories

Henry I. Dorr Professor of Research in Anaesthesia, and chief of the anaesthesia at MGH. Standing on what was possibly the very spot Dr. Morton had stood on 119 years ago, Dr. Beecher said he was "well aware that many consider the field of anesthesia to be a narrow one. But nearly fifty years ago, R. S. Lillie said, 'The problem of the general nature of anesthesia is in fact inseparable from the wider problem of nature and conditions of irritability in general.' The irritability of a single cell and the factors which modify this lie at the center of all problems, of all biology. Here is the central problem of life itself." Dr. Beecher went on to give examples of the breadth and interlocking relationships of anesthesia in other areas of biological and psychological interest. He talked of the experiments he and Dr. Jane Denton performed in 1949 which showed that "experimentally contrived pain simply does not respond to morphine or other powerful analgesic agents, whereas pain of pathological origin always responds in greater or lesser degree to morphine . . . at the same time experimentally contrived pain in animals does respond to morphine. Presumably, all pain is serious and significant to an animal, for the animal is unable to distinguish between pain of pathological origin and that experimentally produced. From this we got the tip that the significance of the wound seemed to be the important factor." Recently, Dr. Beecher and his colleagues have probed the mystery of why contrived pain does not respond to morphine. They now know that pain produced in sudden, fleeting, pricks, jabs and stabs will not respond to morphine, whereas really severe, sustained pain, "even though it is experimentally contrived will respond to morphine in a smooth fashion." Dr. Beecher felt the finding was important in two respects: as a practical method to appraise in man the effectiveness of pain-relieving agents, and philosophically as an insight into the factors involved in pain relief. "Once again," he concluded, "if I may be forgiven for harping on an old theme, it is evident that truly basic advances in science, advances of a conceptual nature, can be made in the clinic, derived from study of man."

Those fitting words carried with them whispers from the past and confidence for the future. It is surely true that much more knowledge will continue to be derived from the study of man at the Massachusetts General, and that, gentlemen, is no humbug.

Grave Antagonism

Death for the protagonists of the Ether Controversy did not, in the words of Francis Bacon, "openeth the gate to good fame, and estinguisheth envy." An article, "The Ether Controversy Revisited,*" by Milton H. Alper '54, clinical associate in anesthesia, points out that both Morton and Jackson are buried in Mount Auburn Cemetery, Cambridge, Mass., but "geographically, at least, Dr. Jackson lies higher than Dr. Morton. Jackson's epitaph states his claim: . . . through his observations of the peculiar effects of sulphuric ether on the nerves of sensation and his bold deduction therefrom, the benign discovery of painless surgery was made." While lower down the hillside Morton's monument simply states: "Wm. T. G. Morton, Inventor and Revealer of Anaesthetic Inhalation . . . Before whom in all time surgery was agony, By whom pain in surgery was averted and annulled, Since whom Science has control of Pain."

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